IMPACT PLUS
REQUEST FOR SERVICES (RFS)

Region Name_____ Region #_____

Child's Name _____ Medicaid # _____ DOB_____

Service Coordinator and Agency _____ Phone #_____ Fax #_____ Supervisor_____

Service Coordinator Agency Address: _____ City _____ State _____ Zip Code _____

Name of required Behavioral Health Professional present at Team Meeting_____ Phone_____

Is the recipient currently committed to DCBS care? Yes or No Print Name of Parent/Guardian/Primary Caregiver _____
(This request cannot be processed without the commitment status indicated.)

This request is a (an): _____Initial Request for Services (RFS & Service Plan) _____ Continued Service Review (RFS, Contact log, Progress Report, and Service Plan – when applicable)

Shaded areas ONLY to be completed by Healthcare Review Corporation

Service	Region	Date Service to BEGIN	Date Service to END	Frequency of Service (# of times per month)	Intensity of Service (length of session)	Sub-Provider & Organization and Credentials Agency name must be IMPACT Plus billable name.	Total # of Units Requested	Request Approved (HRC use only)	Approval Dates (HRC use only)
Examples: (Therapeutic Child Support, BA)	**6J**	**(7/01/00)**	**(7/31/00)**	**4 times**	**(one hour per week)**	**(Agency Name, Person Providing Service and LCSW, or BA, or MA, etc.)**	**4**	**(Leave Blank)**	**(Leave Blank)**

****PLEASE REMEMBER TO USE AGENCY'S IMPACT PLUS BILLABLE NAME**

****Clearly indicate what region is providing that particular service.**

*****If this form includes a request for residential care or crisis stabilization, the name of the Sub-Provider of residential or crisis stabilization, contact person, telephone and fax number must be stated below:**

_____ _____ _____ _____
Sub-Provider/Agency Name **Contact Person at Agency** **Telephone** **Fax**

Comments_____

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07/23/03